Wakely
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Maryland Health Benefit Exchange: Exchange Operating Model Vendor Report

November 8, 2011

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Executive Summary

Wakely Consulting Group completed this report to support the Maryland Health Benefit Exchange Board of Directors as it prepares to present recommendations to the Maryland General Assembly with respect to the Exchange's approach to the certification of Qualified Health Plans (QHPs), as well as the Exchange's recommended approach to regional contracting. In addition to this report, Wakely presented to and assisted with the facilitation of three meetings to support the Operating Model & Insurance Rules Advisory Committee during October and November of 2011 as that committee considered these issues. The findings of this committee are included in a separate report to the Exchange Board. With respect to QHP certification and regional contracting, the key messages from this report include the following:

1. Determining an approach to QHP certification is not an either/or choice between being "selective" and being "facilitative". Rather, the Exchange has a broad range of options along a continuum of standardization and selectivity which allow the Exchange to calibrate how selective and/or facilitative it chooses to be with any given aspect of health plan certification.

2. A key decision facing Maryland in the short term is whether to allow the Exchange the flexibility to include additional criteria for health plan certification above and beyond the minimum specified in the ACA and/or whether the Exchange will have the flexibility to be selective in certifying health plans. If the answer to these questions is "yes", the Board will be able to situate itself along the continuum of selectivity or standardization that is most appropriate given the goal, timing, and market conditions.

3. Because of the nature of the organization as set forth in the ACA and subsequent federal guidance, the Exchange faces certain constraints on its ability to directly affect plan elements such as affordability owing to its identity as a rate taker (i.e., not able to set or fix premium levels) and its participation in a community rated risk pool (as opposed to a closed risk pool).

4. Establishing short and long term goals is a critical first step in determining an approach to QHP certification, as the strategy and criteria established for QHP certification, as well as the level of standardization and/or selectivity, will follow upon the goals selected by the Exchange and the relative priority of these goals.

5. The Exchange may change its approach to QHP certification over time, as the entity grows in size, builds market credibility, and as goals and market conditions shift. For example, the Exchange may focus initially on attracting plans and building membership scale, and may later focus on improving care quality, influencing delivery system change, and focusing on affordability.

6. There is a certain level of regional contracting that is built into the design of the Exchange, because two national plans selected by the federal Office of Personnel Management that meet state-specific certification criteria are expected to be included in every Exchange. Beyond this, the conventional definition of regional contracting – working with another states Exchange – would require Maryland to coordinate plan selection across borders and jointly establish standards. In addition, plans would need to meet licensing and other regulatory requirements in both states.

I. Introduction

This report is submitted to the Maryland Health Benefit Exchange under a contract awarded in September, 2011 as part of a series of studies outlined in Maryland's Exchange enabling legislation to address different options for the Exchange's operating model, which is interpreted in the Request for Proposals as primarily addressing the Exchange's options with respect to the certification of Qualified Health Plans (QHPs) as well as the Exchange's options with respect to regional contracting.

As specified in the Request for Proposals, the Exchange is required to provide the General Assembly with a report by December 23, 2011 that studies and makes recommendations on the Exchange operating model. The key components of this report are to address Exchange options relating to the following:

1. Selective contracting, either through competitive bidding or a negotiation process similar to that used by large employers, to reduce health care costs and improve quality of care by certifying only those health benefit plans that meet certain requirements such as:

    - promoting patient–centered medical homes,
    - adopting electronic health records,
    - meeting minimum outcome standards,
    - implementing payment reforms to reduce medical errors and preventable hospitalizations,
    - reducing disparities,
    - ensuring adequate reimbursements,
    - enrolling low–risk members and underserved populations,
    - managing chronic conditions and promoting healthy consumer lifestyles,
    - value–based insurance design, and
    - adhering to transparency guidelines and uniform price and quality reporting.

2. Multistate or regional contracting

Wakely Consulting was asked to provide the Exchange Board and advisory committee with analytic support to foster informed discussions as well as to publish a neutral, informative final report of the options, and objective strengths and weaknesses of each. This report, along with deliverables produced by the advisory committee, will be incorporated into the Exchange's December 23, 2011 report making recommendations to the Maryland General Assembly.

This paper will outline some of the key concepts for the Board to consider when determining the appropriate model for selecting and certifying QHPs, some key market information specific to Maryland that will affect the operating environment and options for certifying QHPs, as well as the pros and cons of different approaches to health plan certification. In addition to this report, Wakely Consulting provided support and information to the Operating Model advisory committee during a series of meetings held in October and November of 2011. Presentation and background materials from those meetings have been included as attachments to this report.

II. Role of the Exchange

As contemplated in the Affordable Care Act (ACA), state-based health benefit exchanges will have a wide range of responsibilities, including determining eligibility for subsidized benefits, developing and maintaining a web-based portal to shop for and purchase health insurance, conducting consumer outreach and reporting, managing Navigator organizations, reconciling federal premium and cost-sharing subsidies, and many other functions. Their most central function, however, will be selecting, certifying, offering for sale, and marketing Qualified Health Plans (QHPs), the actual insurance products into which qualified individuals and small business may enroll through the Exchange. In this area, the Exchange has four key functions: (1) developing standards or criteria for QHP certification and a mechanism to award this certification; (2) monitoring QHP compliance with these standards and decertifying non-compliant plans; (3) offering QHPs for sale and marketing these plans to individuals and small businesses, and (4) developing plan rating criteria, measuring plan performance, and communicating plan rating information to consumers. This report will focus primarily on the first of these functions, developing standards or criteria for QHP certification and a mechanism to award this certification.

The ACA outlines the minimum standards that QHPs and their issuers must meet in order to be certified and offered through the Exchange. These minimum standards are appended to this document as **Attachment 1**, and summarized in **Table 1** below. The minimum criteria are primarily focused on compliance with state and federal regulatory requirements, and participation and alignment with other ACA-stipulated programs, including ACA risk mitigation programs and quality reporting and plan rating.

Table 1. Summary of ACA Minimum Criteria for QHP Certification

- State-based Licensure Compliance
- Compliance Offering Requirements
    - Must offer Silver/Gold/Child Only
- Rating Rules Compliance
- Network Adequacy
- Transparency in Coverage
- Quality Standards Compliance
- Marketing Compliance
- Risk Adjustment Participation and Compliance
- Accreditation Standards Compliance
- Premium Rate Submission Compliance
- Benefit Design/Essential Benefits
- Service Area Coverage
- Enrollment Process Compliance
- Non-discrimination

In addition to requiring QHPs and issuers to meeting the minimum criteria outlined in the ACA and subsequent federal guidance, the law allows states the flexibility to also adopt additional standards and criteria, over and above those included in the ACA, that the Exchange deems in the "interest of qualified individuals and qualified employers" seeking to enroll in coverage through the Exchange. This provision gives states wide latitude in determining what other factors to consider when certifying QHPs. Some examples of additional criteria that could be adopted by the Maryland Health Benefit Exchange are included in the list below.

- Promoting patient-centered medical homes
- Adopting electronic health records
- Implementing payment reforms to reduce medical errors and preventable hospitalizations
- Reducing disparities
- Ensuring adequate reimbursements

- Enrolling low-risk members and underserved populations
- Managing chronic conditions and promoting healthy consumer lifestyles
- Adhering to transparency guidelines and uniform price and quality reporting
- Meeting Exchange premium cost standards
- Value-based or limited network benefit designs
- Participating in Exchange-sponsored marketing initiatives
- Meeting Exchange membership targets
- Meeting minimum outcome standards
- Adhering to provider contracting or geographic access requirements

These examples are illustrative; other types of criteria could be included. It is important to note that cost *can* be a consideration in awarding QHP certification, but the Exchange is not able to "set" or "fix" prices for products sold through the Exchange. As will be further discussed in the next section, premium prices for products sold through the Exchange must be the same as prices charged for the same product outside the Exchange, and must comply with applicable state and federal rating rules for the small or non-group market segments.

Finally, the state Exchange is given similar flexibility in determining the mechanism by which it will award certification to QHPs. The most recent federal Notice of Proposed Rule Making (NPRM) outlines four illustrative examples of acceptable certification processes, and indicates that states can use discretion in applying these or other methods to certify QHPs for participation. The four outlined in the NPRM include:

1. Utilize an "any qualified plan" model – i.e. allow any plan to participate that meets the minimum federal criteria
2. Develop selection criteria beyond minimum standards and permit participation to any plan that meets these additional criteria – i.e. an expanded version of #1
3. Competitive bidding or selective contracting model – i.e., state can select a limited number of plans or products to offer through the Exchange (for example, through a competitive RFP process)
4. Negotiate with carriers on a case-by-case basis, after carrier has met minimum certification standards, again allowing the state flexibility to limit the number of plans or products that participate in the Exchange

These illustrative models, as well as their pros and cons, will be discussed in more detail later in this report.

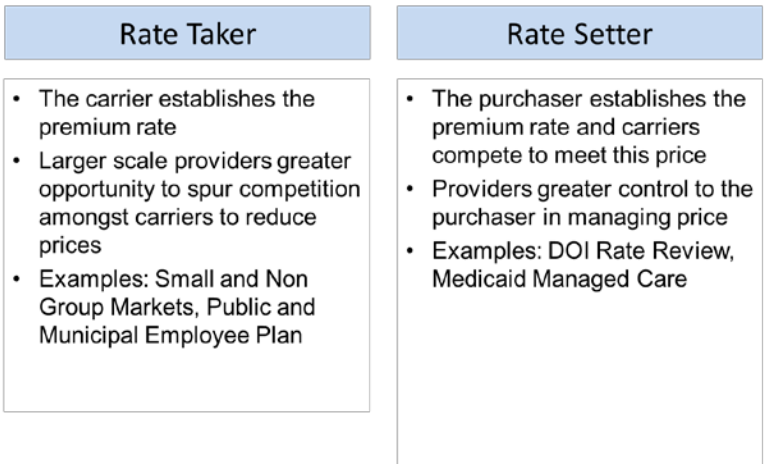
III. Key Concepts and Levers for QHP Certification

The Exchange has three main levers it can use to affect the market, which it must employ and coordinate to create carrier interest in participating in the Exchange and achieve its goals: (1) the QHP certification and criteria it adopts; (2) the target populations it is able to enroll in coverage; and (3) the plan rating criteria it develops and the way in which it deploys this information. To achieve the desired level of impact or influence on the market and to achieve its goals, the Exchange must coordinate its use of these three levers. For example, by establishing criteria and calibrating the level of selectivity incorporated into the selection process, the Exchange can shape the types of plans and products included on the Exchange. The degree to which this process affects the broader market, or balances selection criteria with other Exchange goals such as product choice or

enrollment scale, will depend on how the Exchange uses its second lever, the target population(s) the Exchange is able to market to and enroll. The expected mix and size of this population will both affect how attractive the Exchange is to different carriers, as well as determine the impact its certification criteria have on the overall market. If the Exchange attracts a large number of enrollees, it is more likely that it can be more stringent in its certification criteria and still attract interest from multiple carriers, and also more likely that selection criteria (for example, related to delivery system change or care quality) will have a material impact on the overall market. Finally, the Exchange's third lever, plan rating criteria and reporting, while not a direct component of QHP certification, can be coordinated with Exchange selection criteria to complement and support Exchange goals. For example, these criteria may highlight an element of health plan performance related to a certain quality measure that is also addressed through the QHP certification criteria. Alternatively, if the Exchange elects a less-selective or stringent certification approach, it may seek to share information with consumers through its plan rating criteria that highlights plan performance along dimensions important to the Exchange, thereby highlighting differences in plan performance (and, ideally, encouraging progress toward Exchange goals) without including these elements into the certification process itself.

The ability of the Exchange to accomplish goals using these three levers will be affected and/or constrained by a few key elements embedded in the way the ACA has structured state-based exchanges. The first critical concept that shapes the health plan certification process is the distinction between being a **rate setter** versus being a **rate taker**. In the context of health benefit purchasing, being a rate setter means that the entity has the ability to set the price of a given set of benefits. For example, in the state of Maryland, the Medicaid Managed Care Program is a rate setter. While the state has not historically engaged in a selective contracting process, it establishes the rate of compensation that participating Managed Care Organizations (MCOs) will be paid for each member they enroll. MCOs that wish to participate must accept this level of payment. In contrast, a business purchasing insurance through the small group insurance market is a rate taker. They may shop for insurance amongst different carriers, but they are not able to set the price they will pay for insurance coverage, as these rates are established by carriers for all small employers based on Maryland insurance rating regulations.

Figure 1. Rate Taker vs. Rate Setter



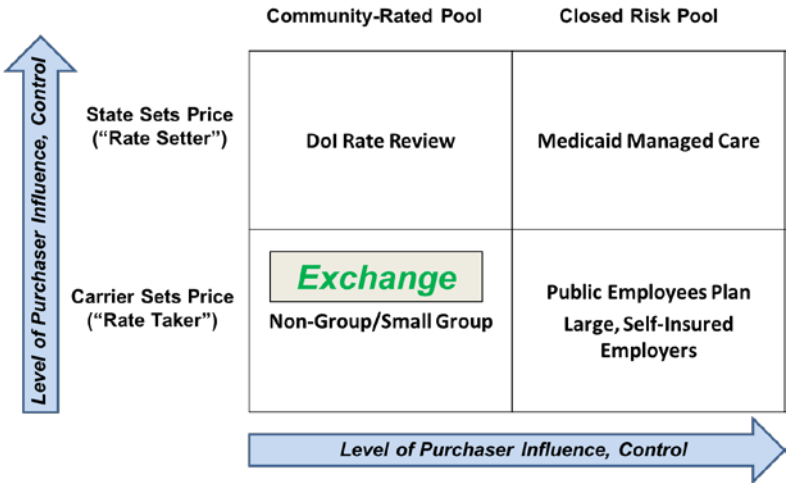
Like small businesses, large employers, such as public employee benefit plans (if fully insured), are rate takers, as they typically don't set the premium rate offered to them by participating health

plans. However, they have a greater ability to influence price and/or spur competition amongst carriers than do small employers. This is the case not only because they are larger in scale and therefore offer a carrier greater volume of membership, but also because their larger, captive population constitutes a **closed risk pool**, which stands in contrast with a **community rated pool** to which the small employer belonged. In a closed risk pool, the purchaser brings to the market a large, monolithic block of enrollment whose risk and historical cost experience can be analyzed as a unique entity. This allows carriers to price these large blocks more aggressively than they are able to in the small group market, where small group size leads to more volatility and unpredictability in medical costs. In contrast, a community rated pool (such as the small group market) is typified by small group sizes, which leads to uncertainty and more conservative pricing practices. In this market, because carriers cannot accurately assess the risk of any individual group, their pricing is based on the market as a whole. Further, pricing adjustments between groups or individuals (e.g., for age, gender, geography) are set by law and must be consistent inside and outside the Exchange. Because of these factors, coupled with their small enrollment, small business and individuals have limited ability to influence price and quality.

Figure 2. Community Rating vs. Closed Risk Pool

Based on the schema outlined in Figure 3, below, the Exchange is a **rate taker** that will be selling insurance in a **community rated** risk pool (the non- and/or small group markets). Although it is able to influence the price of products through the benefit designs and other factors included in the certification process, the Exchange is not able to set prices for the policies that it sells, as the prices for products sold through the Exchange are subject to small and non-group rating rules and must be the same for the same product sold inside and outside the Exchange. The Exchange is not purchasing a monolithic block of business that can be analyzed in the same way as a large employer's population; rather, it is helping to organize the purchase of insurance by numerous smaller groups, for whom the claims experience is unpredictable, just as it is in the outside market place.

Figure 3. Types of Purchasers



Having an understanding of the constraints on the Exchange's ability to directly affect affordability and other goals through its plan selection process is important for the board as it weighs approaches to health plan certification. Advancing goals like affordability and quality improvement are possible for the Exchange, but doing so will require creativity on the part of the Exchange and careful consideration of the insurance marketplace; for example, in the way that it develops or deploys certain types of benefit designs or product features.

Enrollment scale is a critical element of the Exchange's ability to attract and incent carriers, as well as to influence carrier behavior or the broader health care market. Although the Exchange, as indicated above, is a rate taker and operates within a community rated risk pool, the larger the scale of membership purchasing through the Exchange, the more it begins to resemble a large purchasing pool, the more attractive it becomes for carriers to participate, and the more influence it can exert over key priorities such as affordability, benefit design, and quality features. Because carriers must rate their products based on their entire book of business, the larger Exchange enrollment becomes as a share of that book, the more flexibility carriers will have in their pricing to account for Exchange business. Thus, should the Exchange adopt the long term goals of improving affordability or influencing delivery system change, an intermediate goal to consider may be to grow membership scale through the Exchange. The importance of goal setting and its impact on approach to QHP certification selected by the Exchange is discussed in the next section.

IV. QHP Certification Dimensions

The strategy and structure of Exchange QHP certification will be driven by the goals that the Exchange hopes to achieve, since different goals, as well as different levels of priority amongst goals, will lead to different types of certification strategies. In our experience, focusing on a limited number of goals is most likely to produce concrete success. Goal setting is therefore a critical component to developing an approach to QHP certification.

It is useful to think about goal setting in relation to two dimensions: short term vs. long term, and internal vs. external.

Short Term vs. Long Term

Short term goals are issues that the Exchange can achieve in a short period of time with the influence or existing leverage it possesses during the initial phases of operations. These can be thought of as "quick successes" to establish the Exchange's identity; develop relationships with carriers, enrollees, vendors, partner agencies, and other stakeholders; and build market credibility. Examples of short term goals include: simplifying the consumer shopping experience, providing a wide array of plans and/or products, and building membership scale.

Long term goals are issues for which time and/or membership scale are required elements, and can address things with more significant impacts on the outside market. Examples of long term goals include: improve carrier performance on quality metrics, foster delivery-system change, and reduce premium trend in the small and non-group market.

Exchange-specific vs. External Market

In addition to distinguishing between short and long term goals, Exchange goal-setting should balance both larger, market-oriented goals with goals important to the establishment and operations of the Exchange.

Exchange-specific goals include things that are important to the Exchange that may not be relevant to the outside market, such as the development of strong stakeholder relationships, carrier compliance with data reporting requirements and claims data submission, securing the appropriate mix of products to offer and market, or securing long-term commitments from carriers to foster stability in Exchange offerings.

External market goals include items affecting the broader health care market as well as more high-profile elements around which public expectations are high, such as controlling premium cost trends, expanding insurance coverage, or enhancing and simplifying the shopping experience for individuals and small groups.

Figure 4. Illustrative Examples of Exchange Goals Along Two Dimensions

	Internal	**External**
Short Term	• Provide desired level of choice • Create administratively easy interface for carriers	• Develop scale in Exchange; increase insurance coverage • Create simple enrollment experience
Long Term	• Exchange purchasing is coordinated with Medicaid or other public payers • Exchange is self-sustaining	• Mitigate premium trend • Increase member access to providers • Allow for ACOs/Safety Net-sponsored entities to be offered on Exchange

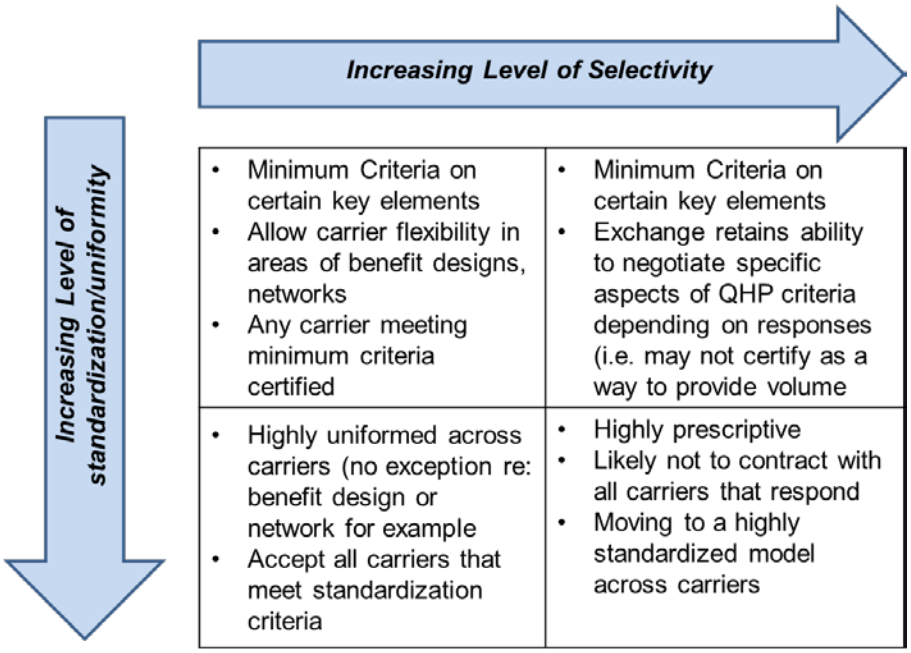
V. Evaluation of Certification Models

It is common when discussing models for QHP certification to contemplate two mutually exclusive approaches to health plan certification: "selective" and "facilitative". In this rubric, "selective" suggests an active, competitive procurement process, including the imposition of significant additional criteria, and a heavy emphasis on employing the procurement process to drive significant cost or quality improvements to the existing market. Often included in this view is the idea that choice of health plans and/or products will be limited and/or highly standardized. "Facilitative", on the other hand, suggests an "any willing plan" model in which no additional requirements above the ACA minimum standards are included, and any plan or product that meets these minimum standards is allowed to participate in the Exchange. In this view, choices of plan and product offerings are maximized, and the Exchange does not seek to standardize offerings or limit participation.

In contrast to this binary view of certification options, the decision required of the Exchange in selecting an approach to QHP certification is not black and white. Rather, there is a spectrum or continuum of selectivity and standardization along which the Exchange can calibrate its own approach to certifying health plans. Further, the Exchange can position itself at different points along this continuum for different elements of its certification process based on the goals it has selected and the level of priority attached to different goals.

Figure 5, below, highlights two dimensions for health plan certification. The first dimension, standardization, reflects the level of uniformity that will be required of health plans selected to participate in the Exchange. The second dimension, selectivity, reflects the ability of the Exchange to limit the number of participants based on key criteria, or, in some cases, to limit participation from plans that meet required criteria, but who do not meet Exchange goals for quality, affordability, or other key factors. While this is a useful construct for considering the Exchange's overall approach to QHP certification, it is important to note that the idea of a continuum in these two dimensions can be applied to each specific goal the Exchange sets for its certification process. In other words, the Exchange may adjust the level of selectivity and/or standardization it ascribes to any individual goal, and in fact, in reality, this will likely be necessary to make trade-offs between goals based on the relative level of priorities the Exchange establishes for these goals.

Figure 5. Dimensions of QHP Certification



To illustrate this concept, consider an illustrative scenario based on a hypothetical certication process. The example cited below is for illustration only; Wakely does not advocate the adoption of these goals or criteria, nor opine on the likely response of carriers to any individual goal. In this example, a sub-set of the Exchange's goals for its QHP certification process may include Enrollment Growth, Stability/Attracting Carrier Participation, and Improving Geographic Access. The initial priority attached to each goal is "High", and the corresponding translation of these goals to QHP certification criteria is reflected in Table 2, below.

Table 2. Illustrative Example of a Sub-set of Initial Exchange Certification Goals

Goal	Selectivity	Certification Criteria/Terms
1. Enrollment Growth	High	Seek to offer at least 6 carriers, including the top five in the market representing at least 95% of NG/SM market
2. Stability / Attracting Carriers initially	High	Contract for an initial term of 2-3 years, with an option held by the Exchange to add additional carriers after year 2
3. Access	High	Require carriers to minimally offer in the same regions as currently. For those carriers, willing to expand, preferred placement in web comparison shopping page

Continuing with this example, in this scenario, once the Exchange communicates these goals to carriers, it finds carriers resistant to the third goal related to geographic access, based on cost concerns related to significantly expanding their provider network. Because maintaining a high level of priority for this third goal may jeopardize the ability to achieve goals one and two, in this

scenario, the Exchange may choose to reduce the level of selectivity and/or standardization for goal three to strengthen their ability to achieve goals one and two. A revised list of goals, priorities, and related criteria is included in Table 3, below.

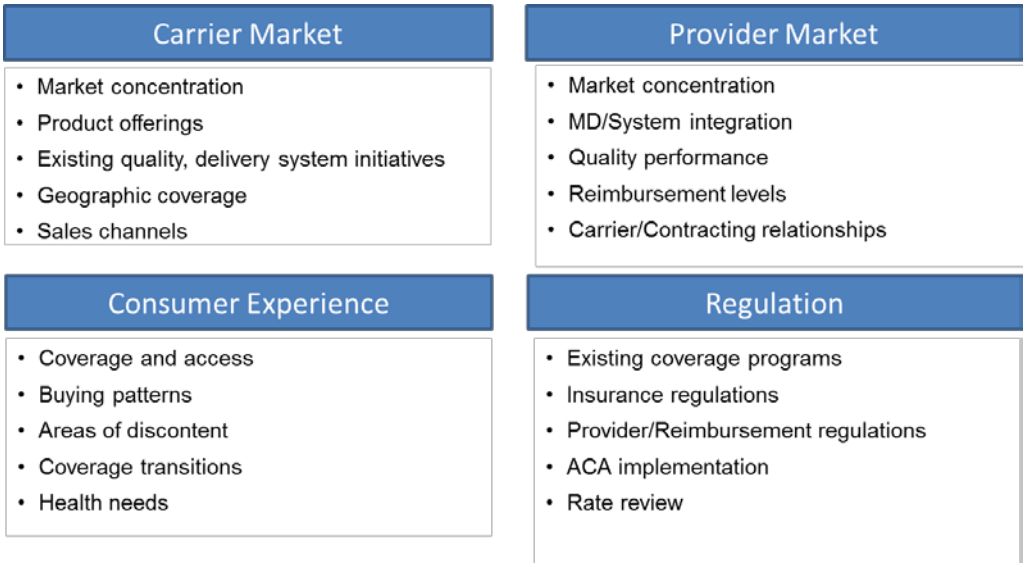
Goal	Selectivity	Certification Criteria/Terms
1. Enrollment Growth	High	Seek to offer at least 6 carriers, including the top five in the market representing at least 90% of NG/SM market
2. Stability / Attracting Carriers initially	High	Contract for an initially term of 2-3 years, with an option held by the Exchange to add additional carriers after year 2
3. Access	Low	Carriers must provide reporting related to geographic access and network adequacy

The hope in offering this illustrative example is not to advocate or suggest an approach to QHP certification, but to highlight the fact that (a) how the Exchange establishes goals will be a major determining factor in the QHP certification approach it adopts and (b) the Exchange has the freedom and flexibility to establish the level of selectivity and/or standardization it deems appropriate, not only for the process as a whole, but for each specific goal or sub-component of the process. In actuality, the process of certifying QHPs will likely involve trade-offs between different priorities to move closer to the Exchange's overall vision for the process. Having a clear sense beforehand of what the primary goals, and their relative priority, will prove invaluable as the Exchange works its way through the certification process.

VI. Market-specific Data

The goals of the Exchange, as well as the selected approach to QHP certification to attain these goals, will be heavily shaped and influenced by the structure and features of the health care market in which it will operate. Some of the key factors that will shape the approach selected by the Exchange are outlined in Figure 6, below.

Figure 6. Key Market Factors

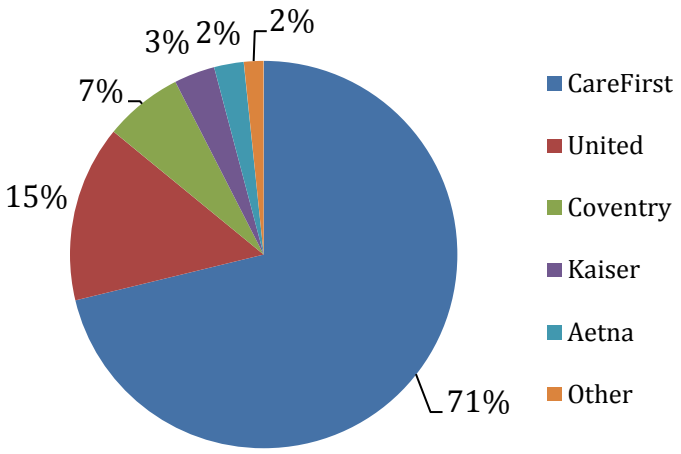


With respect to Maryland, we will discuss three important market factors that will bear on the Exchange's decision making process with respect to both QHP certification and regional contracting: market concentration, Maryland's unique regulatory environment, and the lack of overlap between the Medicaid and commercial insurance markets.

Market Concentration

Both the non- and small group markets in Maryland are highly concentrated, with similar distribution by carriers. CareFirst accounts for 71% of the total small and non-group market. Overall, five carriers account for 98% of the market. This is an important factor for the Exchange to consider in relation to carrier participation and enrollment scale, as the extent to which dominant market players participate may have a determining impact on the membership scale and level of choice provided to enrollees through the Exchange. At the same time, the opportunity to distinguish themselves in a new marketplace may be a compelling opportunity for new market entrants that makes participation in the Exchange more appealing.

Figure 7. Maryland Small and Non Group Combined Market Share, 2010



Source: Maryland Insurance Administration, 2010.

Unique regulatory structure

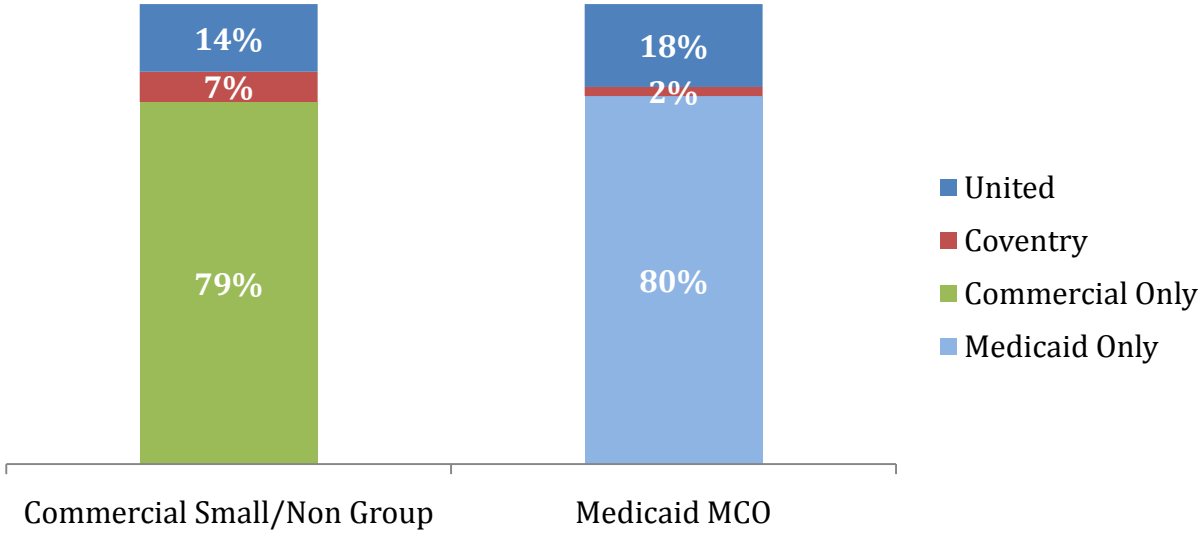
Maryland's health care market has two unique regulatory features that set it apart from most other states: all-payer hospital rate setting, as well as the market regulations in force for small group insurance, including the Comprehensive Standard Health Benefit Plan. Maryland's unique rate setting methodology places some limits on the ability of carriers to achieve greater savings through network contracting. Hospital rates for all payers are regulated by the Health Services Cost Review Commission (HSCRC), which provides Maryland greater long term cost control abilities but limits carrier opportunities to further impact affordability through preferred rates. Network composition (i.e. limiting networks), product design, delivery system changes (PCMH, global budgets) and utilization management may be other options to enhance affordability. In addition to the HSCRC, the small group market in Maryland is subject to a number of rating rules, including guaranteed issues, community rating, and the requirement to meet minimum benefit standards as mandated by the Comprehensive Standard Health Benefit Plan (CSHBP), developed and managed by the Maryland Health Care Commission (MHCC). Under this requirement, small group plans must meet the standards set forth under the CSHBP, which are updated periodically to ensure the minimum plan remains affordable. While prescriptive in establishing a benefit floor, the regulations permit flexibility of firms to obtain policy riders, and the majority of purchasers in this market do obtain a rider (primarily to enhance the prescription drug benefit.) The existing structure of the small group market in Maryland should make the transition to ACA-based rating rules less impactful than this transition would be for a less standardized market place, as carriers, producers, and small firms are used to developing products to meet and/or exceed minimum benefit standards.

Public Program Overlap

Another important consideration is the degree of overlap between the Medicaid MCO and commercial insurance markets. This is important because there is likely to be some movement between these two population pools, and one goal of the Exchange may be to manage these enrollee transitions, or to leverage participation on the part of health plans in one market to incent their partipation in another (e.g., to link the procurement of benefits through the Exchange to their participation in another program). Based upon our review of market share across these two

markets, we found that only two carriers participate in both the commercial small and non-group markets and the Medicaid MCO market, accounting for approximately 20% of both markets. While this suggests little current overlap between these markets, this structure may allow for future opportunities for current participants in one market to participate in the other market.

Figure 8. Market Overlap Between Maryland HealthChoice and Commercial Market



Sources: Maryland Insurance Administration, 2010; Maryland HealthChoice Program, 2010.

VII. Discussion of Specific Options

As part of the most recent notice of proposed rule-making issued by CMS, the federal government outlined four examples of certification process models that would be deemed acceptable under the ACA. While not prescriptive in the sense that a state could design a process that is not included in these examples, it is a useful starting place to identify different types of approaches that could be taken by Maryland when selecting QHPs. In the following section, we identify the four approaches, and highlight pros and cons from each.

1. Utilize an "any qualified plan" model

In this option, the Exchange would adhere to the minimum standards specified in the ACA, and permit any plan that meets these standards to offer products for sale through the Exchange. The Exchange would not limit participation to any qualified plan nor limit the products offered by plans through the Exchange.

Pros:

- Maximum choice in products and plans
- Provides greater chance to build scale by being more inclusive

- If supported with reporting on plan performance and support tools, gives consumers greater ability to find benefits that most fit their needs

Cons:
- Too much choice can be confusing to members and diminish buying experience
- Limits Exchange ability and flexibility in using certification process to advance other goals
- Minimum standards may not attract carriers necessary for successful Exchange

2. Develop selection criteria beyond minimum standards

This option is essentially an expansion of Option 1. The state would continue to allow any qualified plan to participate in the Exchange, but would include additional criteria over and above those outlined in the ACA.

Pros:
- Provides Exchange ability to advance some additional goals without limiting carrier participation
- Provides Exchange flexibility to include or not include standards that are more or less stringent based on particular context/market factors

Cons:
- Calibration of standards important to ensure desired level of participation
- Exchange ability to maximize influence for certain factors may require ability to not include all carriers
- Could result in negative outcome for some carriers wishing to work with Exchange

3. Competitive bidding or selective contracting model

In this option, the Exchange would conduct a competitive procurement process, for example, by issuing a competitive RFP and selecting some or all plans that provide appropriate responses. The Exchange could include additional criteria above and beyond those specified in the ACA, and could also elect not to include all respondents or otherwise limit participation based on plans that best meet the standards set forth in the procurement.

Pros:
- Provides greater ability to influence plan features, affordability, and advance quality/policy goals
- At large levels of enrollment, allows the Exchange to have market-wide impact on key goals

Cons:
- Does not require Exchange to exclude carriers, but creates potential that some carriers will not participate
- At low levels of enrollment, Exchange value proposition may not be sufficient to attract competitive proposals

4. Negotiate with carriers on a case-by-case basis, after carrier has met minimum certification standards

Pros:

- Provides Exchange greatest level of flexibility in establishing criteria and terms for participation
- Allows refinement of Exchange/carrier relationship based on feedback and dialogue

Cons:

- Does not require Exchange to exclude carriers, but creates potential that some carriers will not participate
- Exchange ability to achieve goals depends on value proposition to carriers for participation
- Will require effort on the part of Exchange to ensure process remains transparent

Although there is an inherent difference in the level of selectivity and/or standardization between these options, all options, except for Option 1, provide states a considerable level of flexibility to select the desired level of standardization and/or selectivity. For example, even within a competitive procurement, there are gradations of selectivity and standardization that the Exchange can incorporate to be more or less stringent on any given dimension. Thus, regardless of the vehicle selected by the Exchange to select health plans, the critical question the Exchange board may be seeking to answer the following critical questions:

1. Should the Exchange have the flexibility to include criteria over and above those specified in the ACA?
2. Should the Exchange have the flexibility to not include all carriers, if by retaining this flexibility they are better able to advance Exchange goals related to affordability, quality improvement, delivery system changes, or other important short and long terms goals identified by the Exchange?

Once these questions have been answered, the Board will need to determine what level of selectivity, standardization, and stringency will be applied to key certification elements, and whether or not these levels should be altered over time to reflect different market situations and/or Exchange priorities.

VIII. Regional Contracting

Under ACA, states are permitted to work with other states to form combined or regional exchanges, provided all states agree and the arrangement is approved by the federal Secretary of HHS. A part of the task for this review is to assess the feasibility and desirability of the Exchange engaging in multistate or regional contracting. In this section, we outline three primary approaches to regional contracting in the Exchange.

Option 1: Baseline

There is a certain level of regionalism built into the structure of the Exchange, in that two national plans that meet state certification criteria, selected by the federal Office of Personnel Management, will participate in all state exchanges. Thus, the Maryland Exchange will include at least two national plans in common with the surrounding states that move forward with Exchange implementation, as well as the federal fall-back Exchange.

Option 2: Support Cross Border Enrollment

A second option would be to adopt certification criteria that encourage and support the ability of participating QHPs to facilitate cross-border enrollment and/or use of insurance products outside of Maryland. In this option, the Exchange would ensure that qualified plans and issuers had appropriate features in place to help individuals employed in Maryland but living in another state, or businesses based in Maryland with out of state employees, with an adequate ability to utilize insurance products purchased through the Exchange. Such features could include:

- Require QHPS to include product features that enable multi-state coverage (e.g. for businesses with non-MD employees)
- Require issuers to include PPO options in at least some of their Exchange offerings
- Require issuers to include adequate Out-of-Network options in their Exchange offerings
- Include certification criteria to evaluate the breadth and depth of issuers' cross-state provider networks to ensure they provide adequate coverage in nearyby states.

The advantage of this approach would be that, based on Maryland's close proximity to several other states, most carriers currently participating in the market already include features that support cross boarder business, residence, and employment, and requiring such features as part of QHP certification would most likely not involve considerable disruption to the existing insurance market or significant investment on the part of participating carriers.

Option 3: Coordinating QHP Certification with Another State

A third option would involve working with another state to coordinate the certification and offering of QHPs. In this approach, Maryland would work with a neighboring state to, for example, develop joint or reciprocal certification processes, develop consistency in offering across states, or coordinate resources to collaborate on the administrative processes that will support certification, such as data collection and/or the carrier review process. Such an approach would be much more intensive than Options 1 and 2 because working across borders to certify health plans would have important implications for market participation, regulation and licensure. The advantages of regional contracting would be the potential for greater choice for Maryland consumers if the Exchange was able to broaden the number of plans and/or carriers beyond those participating in the current market, broader options for businesses or consumers with cross-border coverage and care needs, as well as the potential to realize administrative savings from sharing key back-office functions related to certification.

However, there would be a number of challenges to such an approach. As discussed earlier, Maryland has a unique market and regulatory structure, particularly in the areas of hospital rate setting and small group product regulations, which impact the ability of carriers to participate in these markets. Further, carriers under ACA must be licensed in

both states in order to participate in both exchanges, creating an additional potential hurdle for carriers seeking to participate in both exchanges. In addition, working with another state to coordinate the standards and criteria utilized to certify QHPs would present a number of challenges, including reaching common ground on the appropriate approach to establishing criteria, addressing the issue of governance and oversight, as well as the potential need for legislation in both states and/or coordinated executive action.

A final consideration, related to the potential goal of enhancing the number of options available to Maryland residents, is that, above and beyond the ability to coordinate functions with a neighboring state, carriers will need to find participating in Maryland an attractive opportunity. In other words, if there are carriers that do not currently participate in the market that Maryland wishes to include on the Exchange, the Exchange and its partners will need to evaluate reasons for this non-participation and/or otherwise incentivize market participation.

Appendices

1. Memorandum to Committee (ACA QHP Requirements) – 10/21/11
2. Memorandum to Committee (Alternate Exchange Models) – 10/21/11
3. PowerPoint Presentation to Committee – 10/3/11
4. PowerPoint Presentation to Committee – 10/12/11
5. PowerPoint Presentation to Committee – 10/25/11
6. PowerPoint Presentation (Supplemental Information) – 10/25/11

MEMORANDUM

TO: Operations & Insurance Rules Advisory Committee

FROM: Wakely Consulting Group

DATE: October 21, 2011

RE: ACA Required Qualified Health Plan Certification Criteria

MINIMUM CRITERIA FOR CERTIFYING A QHP

In determining whether a health plan is a QHP, the Exchange is required and permitted to consider certain criteria regarding the issuer of the QHP and regarding the health plan itself. HHS has offered minimum criteria states should review during the certification process. The Exchange has the flexibility to decide on an "any-willing plan" model or "active purchaser" model. Beyond the criteria outlined below, states have the ability to include additional criteria that they deem to be in the "best interest of qualified individuals and qualified businesses."

Issuer Criteria

Licensing	The issuer must be licensed and in good standing to offer health insurance coverage in each state in which it offers coverage.
Offering requirements	The issuer must offer through the Exchange: • At least one QHP in the silver coverage level, and at least one QHP in the gold coverage level; • A child-only plan at the same level as each QHP offered through the Exchange; and • A QHP that has the same premium rate as the same plan offered outside of the Exchange (if the same plan is offered outside of the Exchange).
Rating variations	• The issuer may vary premiums for the QHP only in accordance with permitted rating variations. • The issuer must charge the same premium rate inside the Exchange as outside the Exchange if it offers the same plan outside the Exchange. • The issuer of the QHP must cover all of the following groups using some combination: individuals, two-adult families, one-adult families with a child or children, and all other families.

Issuer Criteria

Health care quality requirements	The issuer must: • Implement and report on a quality improvement strategy consistent with standards of ACA; • Disclose and report information on health care quality and outcomes described in section 399JJ of the Public Health Service Act and report to HHS at least annually pediatric quality reporting measures consistent with the pediatric quality reporting measures established under section 1139A of the Social Security Act; and • Implement appropriate enrollee satisfaction surveys consistent with the requirements provided by HHS.
Marketing	The issuer and its officials, employees, agents, and representatives must comply with applicable state laws regarding marketing and may not employ marketing practices that discourage enrollment of individuals with significant health needs in QHPs.
Risk Adjustment Program	The issuer must comply with the standards related to the risk adjustment program under 45 C.F.R. pt. 153.
Accreditation	The issuer must be accredited by an accrediting entity recognized by HHS on the basis of local performance of its QHPs with respect to quality and consumer protection in the timeframe required by the Exchange, and the accreditation survey must be provided to the Exchange and HHS. The accreditation must consider clinical quality measures, patient experience ratings, utilization management consumer access, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs.
Segregation of Funds for Abortion Services	The issuer must comply with state law if it prohibits coverage of abortion services in QHPs. Also, issuers must segregate advance payments of federal premium tax credits and cost-sharing reductions to ensure that the funds are not used for abortion services.
Additional Criteria as Determined by the Exchange (not required by ACA)	The Exchange may implement selection criteria beyond the minimum certification standards described above. Example criteria include the issuer's past performance and quality improvement activities.

Plan Criteria

Premium Rate and Benefit Information	• QHP rates must be set for an entire benefit year or for the SHOP, the plan year, and submitted, along with QHP benefits, to the Exchange. • The issuer must also submit required justifications for rate increases in advance of implementation of the increase and post such justifications prominently on its web site. The Exchange may receive this information from the Bureau of Insurance to satisfy its obligations to receive justifications. • The Exchange must consider rate increases in its QHP determination, including consideration of the justification for the rate increase and the rate of premium growth outside the Exchange as compared to the rate of growth inside the Exchange. But HHS encourages the State to avoid duplicating the full rate review process already required under the Public Health Service Act by allowing the Exchange to use the preliminary justification collected by the Bureau of Insurance for the PHSA rate review process and also requiring the Exchange to use the same format for the rate justification as the format required by BOI for its rate justifications. HHS also encourages the State to require the Exchange and BOI to collaborate on the form, manner, and timing of submitting rate justifications. • The Exchange may not consider whether the plan is a fee-for-service plan or provides treatments necessary to prevent patients' deaths in circumstances that the Exchange determines are inappropriate or too costly. • The Exchange may use price as a consideration in certification, but may not "set" prices for participating plans.
Service area of a QHP	• The QHP service area must cover a minimum geographical area that is at least an entire county or group of counties, unless the Exchange determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of the qualified individuals and employers. • The QHP service area must be established without regard to racial, ethnic, language, health-status related factors, or other factors that exclude specific high utilizing, high cost, or medically-underserved populations.

Plan Criteria

Network Adequacy	• The QHP network must provide a sufficient choice of providers for enrollees. • The QHP must make its provider directory available to the Exchange for online publication and to potential enrollees in hard copy upon request. The issuer must note in the directory the providers who are no longer accepting new patients. • The QHP network must include a sufficient number of essential community providers that serve predominantly low-income, medically-underserved individuals. • HHS seeks comment on additional standards under which issuers would be required to maintain; o sufficient numbers and types of providers to assure that services are accessible without unreasonable delay; o arrangements to ensure a reasonable proximity of participating providers to the residence or workplace of enrollees, including a reasonable proximity and accessibility of providers accepting new patients; o an ongoing monitoring requirement to ensure sufficiency of the network for enrollees; and o a process to ensure that an enrollee can obtain a covered benefit from an out-of-network provider at no additional cost if no network provider is accessible for that benefit in a timely manner.
Enrollment Processes and Periods, and Termination of Coverage	The issuer must • Enroll qualified individuals during initial and annual open enrollment periods and make available required special enrollment periods. For the SHOP, issuers must permit qualified employers to purchase coverage at any time during the year. • Collect, accept, acknowledge receipt of, and transmit to Exchange enrollment information and premium payment, in accordance with Exchange processes. • Provide new enrollees with an enrollment information package and provide required summaries of benefits and coverage documents. • Reconcile enrollment files with Exchange or SHOP no less than once a month. • Terminate coverage only as permitted by the Exchange, and provide required notices and grace periods, including for termination by SHOP issuers, notices to employers.

Plan Criteria

Transparency in Coverage	The issuer must provide the Exchange, HHS, and Superintendent of Bureau of Insurance, with information relating to QHP coverage transparency. This information must be in plain English, and the Exchange must ensure that the issuer complies with guidance developed by HHS on the use of plain language. In addition, the issuer must provide cost-sharing information in a timely manner upon request of an individual. Information relating to QHP coverage transparency includes claims payment policies and practices, periodic financial disclosures, data on enrollment and disenrollment, data on the number of claims that are denied, data on rating practices, information on cost-sharing payments with respect to any out-of-network coverage, and information on enrollee rights under title I of ACA.
Non-discrimination	The issuer, with respect to its QHP, may not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.
Benefit Design Standards	The Exchange must ensure that the QHP provides coverage for all of the following: • essential health benefits as described in ACA § 1302(b); • cost-sharing limits as described in ACA § 1302(c); and • a bronze, silver, gold, or platinum level of coverage as described in ACA § 1302(e).
Additional Criteria as Determined by the Exchange (not required by ACA)	The Exchange may implement selection criteria beyond the minimum certification standards above in determining whether a plan is in the best interests of qualified individuals and employers. Example plan-level criteria include reasonableness of the estimated costs supporting the calculation of the health plan's premium and cost-sharing levels, enhancements of provider networks including the availability of network providers to new patients; service area of the QHPs (the size of a service area and the amount of choice afforded to the consumers within that area); and premium rate increases from years preceding the Exchange operation and proposed rate increases.

MEMORANDUM

TO: Operations & Insurance Rules Advisory Committee

FROM: Wakely Consulting Group

DATE: October 21, 2011

RE: Supplemental Information Related to Exchange Operating Models

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I. EXAMPLES OF PRIVATE EXCHANGES

Connecticut Business and Industry Association (CBIA)

CBIA's health insurance exchange, called Health Connections, enables eligible businesses to offer their employees a choice of health plans and benefit levels. Health Connections also provides ancillary insurance coverage, including life, disability, and dental benefits. CBIA Health Connections 2 (3-50 employees) offers more than 25 plans with a range of cost sharing and benefit design from two insurance companies. Benefit designs are standard, but carriers are not required to offer a product for each design. CBIA Health Connections 51+ (51-100 employees) offers similar plans similar plans to those in Health Connections 2. The exchange enrolls roughly 42,000 employees and more than 77,000 members.

Health Connections limits the number of plans participating in the exchanges (through benefit design parameters, for example) to promote competition and reduce potential confusion from having too many marketplace options. Formerly, the exchange offered two levels of coverage (one more comprehensive than the other), but has since transitioned to only offering less comprehensive coverage. Businesses must contribute 50% of premium for lowest cost plan in suite. Standard packages for most popular policies. Previously, there were five carriers participating in Health Connections, but currently only two (Oxford Health Plans and ConnectiCare) are participating.

CaliforniaCHOICE

CaliforniaChoice is a private insurance exchange that markets health insurance to small businesses in California. The organization reports that has approximately 42,000 employees and dependents in the small group market. CaliforniaCHOICE has developed several benefit designs and negotiates rates for these products with a range of health plans. Small firms that join California Choice contract directly with the health plans, using the benefit designs and rates established by CaliforniaCHOICE, rather than contract with the alliance and have the alliance contract with the plans. Individual employees can choose among all the plans covered by California Choice, but the employer must sign a contract with each individual health plan chosen by any employee. CaliforniaCHOICE is explicitly a producer organization, and develops business relationships with carriers as vehicle for presenting and marketing their plans.

Employees are able to take their employer's contribution and apply it toward the health plan and coverage level they like best, choosing from a selection of HMO, PPO and HSA-qualified benefits offered through the available participating health plans. The company works with 5 carriers and offers a limited and somewhat standardized array of benefit plans, which are organized into tiers based on cost-sharing. Design differences do exist between plans offered in the same tier, however. There are 28 HMO options from the five carriers and 4 PPO options from 1 carrier (Anthem).

II. COMPARISON OF UTAH AND MASSACHUSETTS EXPERIENCE

	Utah	**Massachusetts**
State Population	2.8 Million	6.5 Million
Start Up Exchange Funding	$600,000	$25,000,000
Year Established	2008	2006
Total Enrollment (2011)	4,059	217,000
Unsubsidized Enrollment (2011)	4,059	37,000
Total Cost Per Subscriber Per Month	$43.00	$14.51
Carriers Participating	3	8
Market (non-subsidized only)	Small Group Only	Non Group and Small Group
Plan Options (non-subsidized only)	• ~150 • No restriction on benefit designs	• ~56 (not including Young Adult-only plans) • Six standardized benefit plans from each carrier; 1
Affordability	Plan pricing has been higher in HIX than outside, despite efforts to risk-adjust premiums	Non-subsidized: Prices same inside/outside exchange; Subsidized: premium increase has been at or below 5% annually
Funding Mechanism	State funds two staff positions; admin costs for vendors/producers paid by enrollees through monthly fees	Carrier assessment of 3.0 to 3.5% of premiums from exchange business; supports vendors, broker fees, and 40-50 staff
Producer Role	Employers must designate broker of record	Groups can use brokers but not required to

Member fees	All members pay $37 per month for broker fees and $6.00 for TPA	No additional member fees above premium
Functionality	1. Website 2. Enrollment 3. Premium Billing 4. Call center	1. Website 2. Enrollment 3. Premium Billing 4. Call center 5. Eligibility determination 6. Subsidy administration 7. Appeals (mandate and eligibility) 8. Health plan contracting 9. Affordability and minimum coverage regulations 10. Public Information and Outreach 11. Organizational infrastructure

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Maryland Health Benefit Exchange Operating Model and Insurance Rules Advisory Committee

October 3, 2011

Agenda

- Introductions
- Project Overview
- Role of the Exchange
- Concepts for Discussing QHP Certification
- Goals of the Exchange

Introductions

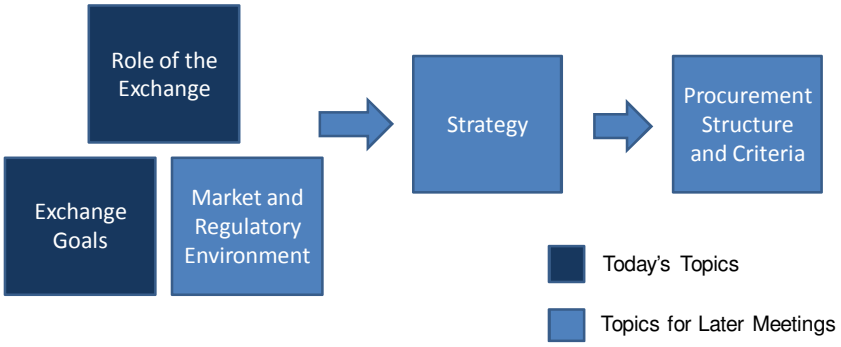
- Patrick Holland, Managing Director
  - Founding CFO of MA Health Connector; responsibilities included leading multiple health plan procurements
  - Extensive private health carrier and provider experience focused on network contracting and negotiation strategy
- James Woolman, Senior Consultant
  - Manager of Finance and Analytics at MA Health Connector; responsibilities included development of procurement strategy and managing health plan analytics
  - Prior experience includes commercial network contracting strategy and Medicaid finance and policy development

Agenda

- Introductions
- Project Overview
- Role of the Exchange
- Concepts for Discussing QHP Certification
- Goals of the Exchange

Project Overview

We will work with the committee to discuss and develop baseline information on the key factors shaping Exchange procurement strategy and then draw on this information to develop options to inform the approach and recommendations for the board.



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Timeline of Committee Meetings

Meeting Date	Discussion Topics
October 3, 2011	• Role and Opportunities of the Exchange • Concepts for Discussing Procurement Options • Identify and discuss procurement goals for the Exchange
October 12, 2011	• Discuss how preferred goals map to procurement strategies • Introduce and discuss procurement approach examples • Introduce how market context can shape strategy
October 25, 2011	• Discuss interaction between market environment and exchange goals in shaping options for procurement approach • Discuss refined procurement approach based on committee feedback from 10/12/11
November 2, 2011*	• Discuss key elements of initial draft report and receive committee feedback
November 7, 2011	• Deliver Final Vendor Report

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Today's Goals

- Provide background on the role of the exchange and how this will shape its options in developing procurement strategy
- Facilitate discussion of Exchange goals for QHP procurement, a critical element in developing QHP strategy and criteria

Agenda

- Introductions
- Project Overview
- Role of the Exchange
- Concepts for Discussing QHP Certification
- Goals of the Exchange

Key Functions of the Exchange

- Develop standards for QHP certification and award certification to qualifying plans
  - Minimum standards per ACA
  - Maryland can go beyond minimum standards
- Monitor QHP compliance and decertify non-compliant plans
- Offer QHPs for sale and market plans to individuals and small businesses

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Key Functions of the Exchange (con't)

- Develop plan rating criteria and communicate plan rating information to consumers

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Exchange is a Health Insurance "Store"

- As a new entity, needs to build market credibility and scale
- Needs to be self-sustaining
- Must offer prospective enrollees a "first-class" customer experience
- Level of service and choice should minimally meet market standards
- Develop relationships with market players

Agenda

- Introductions
- Project Overview
- Role of the Exchange
- Concepts for Discussing QHP Certification
- Goals of the Exchange

Key Levers of the Exchange

The Exchange has three main levers it can use to affect the market, which it must employ and coordinate to create carrier interest and achieve the goals of the procurement:

1. QHP certification process and criteria
2. Target populations to offer and enroll
3. Plan rating criteria

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QHP Criteria Development

- QHPs must meet basic criteria outlined in the ACA and in federal exchange regulations
- The Exchange may develop additional criteria that QHPs must meet in order to participate
- Current guidance provides states wide latitude to determine these additional criteria
- Maryland enabling legislation seeks board recommendations on the contracting role of the Exchange – supported by this project

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Example Criteria

The Exchange has wide latitude to develop criteria. However, it will need to focus on areas it can most readily impact.

- Promoting patient-centered medical homes
- Adopting electronic health records
- Implementing payment reforms to reduce medical errors and preventable hospitalizations
- Reducing disparities
- Ensuring adequate reimbursements
- Enrolling low-risk members and underserved populations
- Managing chronic conditions and promoting healthy consumer lifestyles
- Adhering to transparency guidelines and uniform price and quality reporting
- Meeting Exchange premium cost standards
- Value-based or limited network benefit designs
- Participating in Exchange-sponsored marketing initiatives
- Meeting Exchange membership targets
- Meeting minimum outcome standards
- Adhering to provider contracting or geographic access requirements

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Community Rating vs. Closed Risk Pool

Community Rating	Closed Risk Pool
• Small group size leads to uncertainty and more conservative pricing practices • Pricing adjustments set by law and must be consistent inside and outside the Exchange • Individual groups have limited ability to affect price and quality • Example: Small and Non Group Markets	• Large volume, ability to analyze population risk allow carriers to price more aggressively • Greater scale and ability to directly negotiate provides greater opportunity to impact quality and price • Examples: Public and Municipal Employee Plan, Large Employers, Medicaid Managed Care

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Rate Taker vs. Rate Setter

Rate Taker	Rate Setter
• The carrier establishes the premium rate • Larger scale provides greater opportunity to spur competition amongst carriers to reduce prices • Examples: Small and Non Group Markets, Public and Municipal Employee Plan	• The purchaser establishes the premium rate and carriers compete to meet this price • Provides greater control to the purchaser in managing price • Purchaser can influence price, but also other elements it deems important (networks, quality, etc) • Examples: DOI Rate Review, Medicaid Managed Care

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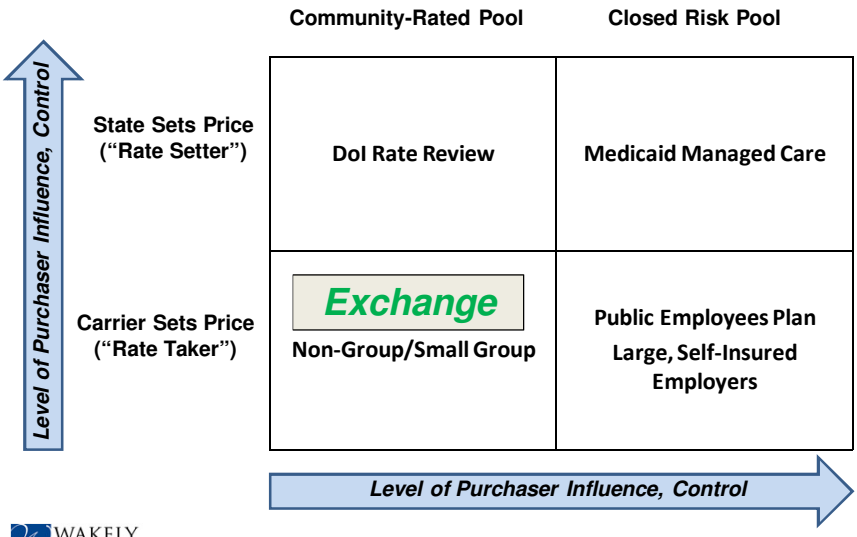
Types of Purchasers



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Agenda

- Introductions
- Project Overview
- Role of the Exchange
- Concepts for Discussing QHP Certification
- Goals of the Exchange

Exchange Goals Overview

- The strategy and structure of Exchange QHP procurement will be driven by the goals that the Exchange hopes to achieve
- Different goals, as well as different levels of priority amongst goals, will lead to different types of procurement strategies
- In our experience, focusing on a limited number of goals is most likely to produce concrete success

Exchange Goals Overview (con't)

- Today's goal is to structure a conversation of exchange goals to help guide our collective work in determining procurement options

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Short Term vs. Long Term Goals

When setting goals, it may be useful for the Exchange to distinguish between short and long term goals.

Short Term	• "Quick successes" to establish exchange identity, develop relationships, and build credibility • Things the exchange is able to achieve with existing leverage: simplify consumer experience, provide wide array of products, build membership scale
Long Term	• Deals with more significant market impact, for which time and/or scale are required elements • Examples: improve performance on quality metrics, delivery-system change, reduce premium trend

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Internal vs. External Goals (Exchange)

Goal-setting should balance both larger, market-oriented goals with goals important to the establishment and operations of the Exchange.

Internal	• Things that are important to the Exchange that may not be relevant to the outside market • Stakeholder relationships, carrier compliance with data reporting requirements and claims data submission
External	• Items affecting broader market and/or around which public expectations are high • Control premium costs, expand coverage, enhance consumer shopping experience

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Goal Setting Examples

	Internal	External
Short Term	• Create simple enrollment experience • Provide desired level of choice	• Develop scale in exchange • Create administratively easy interface for carriers
Long Term	• Exchange purchasing is coordinated with Medicaid • Exchange is self-sustaining	• Mitigate premium trend • Increase member access to providers • Allow for ACOs/Safety Net-sponsored entities to be offered on exchange

Goals do not need to be mutually exclusive – the Exchange can have the same goal for internal and external parties.

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Example Goals by Goal Type

Goal Category	Specific Goal
I. Expand Coverage	1. Reduce uninsured rate
	2. Grow membership scale
	3. Improve access to care
II. Control Cost	4. Reduce premiums relative to existing market
	5. Minimize annual premium increases
III. Impact Service Delivery and/or Quality	6. Improve carrier and/or provider performance on selected quality metrics
	7. Impact delivery system change (PCMH, ACO, Never Events)
IV. Improve Consumer Experience	8. Simplify buying experience
	9. Improve consumer choice
	10. Enhance consumer knowledge and engagement
V. Mitigate Selection	11. Reduce price variation
	12. Prevent selection inside/outside of the exchange

Questions to Discuss

- Goals and priorities for initial procurement process?
  - Short / Long Term
  - Internal / External
- Goals and priorities for later procurement processes?
  - Short / Long Term
  - Internal / External

	Internal	External
Short Term		
Long Term		

Next Steps

Meeting Date	Discussion Topics
October 3, 2011	• Role and Opportunities of the Exchange • Concepts for Discussing Procurement Options • Identify and discuss procurement goals for the Exchange
October 12, 2011	• Discuss how preferred goals map to procurement strategies • Introduce and discuss procurement approach examples • Introduce how market context can shape strategy
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Maryland Health Benefit Exchange Operating Model and Insurance Rules Advisory Committee

Meeting #2

October 12, 2011

Agenda

- Goal of Today's Meeting
- Review Exchange Goals from Previous Meeting
- Discuss Certification Approaches
- Introduce Market Context
- Continue Discussion of Goals and Criteria

Goal of Today's Meeting

- Review goals discussed in previous meeting, prioritize goals (illustrative only), and review procurement options based on stated goals and order of priority
- Continue discussion from last meeting to refine list of goals and solicit feedback on order of priority and tradeoffs

Agenda

- Goal of Today's Meeting
- Review Exchange Goals from Previous Meeting
- Discuss Certification Approaches
- Introduce Market Context
- Continue Discussion of Goals and Criteria

Exchange Goals

Goals (per Comm. Mbrs)	Influenced by Certification Process		
	Yes		No
	Short Term	Long Term	
Stability		✓	
Enrollment	✓		
Delivery System Change		✓	
Manage Chronic Conditions		✓	
Enhanced Benefits			✓
Improving Access	✓		
Care Coordination / Consumer Experience			✓
Minimize Eligibility Churn	✓		
Administration of Subsidy			✓

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Prioritizing Exchange Goals

Exchange Goals	Level of Priority		
	Low	Moderate	High
Stability			✓
Enrollment			✓
Delivery System Change		✓	
Manage Chronic Conditions			✓
Improving Access			✓
Minimize Eligibility Churn		✓	

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Agenda

- Goal of Today's Meeting
- Review Exchange Goals from Previous Meeting
- Discuss Certification Approaches
- Introduce Market Context
- Continue Discussion of Goals and Priorities

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Certification Strategy

- Based on identified goals and the prioritization of such goals, the Exchange certification strategy could be articulated as follows:

> *"Exchange is focused in the short run on growing the size of the exchange, but to do so in a manner that will ensure the stability of carrier/product offerings to its enrollees. In addition, the exchange would like to leverage the QHP certification process to increase physician access, especially for the non-group subsidized population, and minimize churn. Finally, the long-term strategic objective of the exchange is to work with its carrier partners to reform the delivery system in the State of Maryland."*

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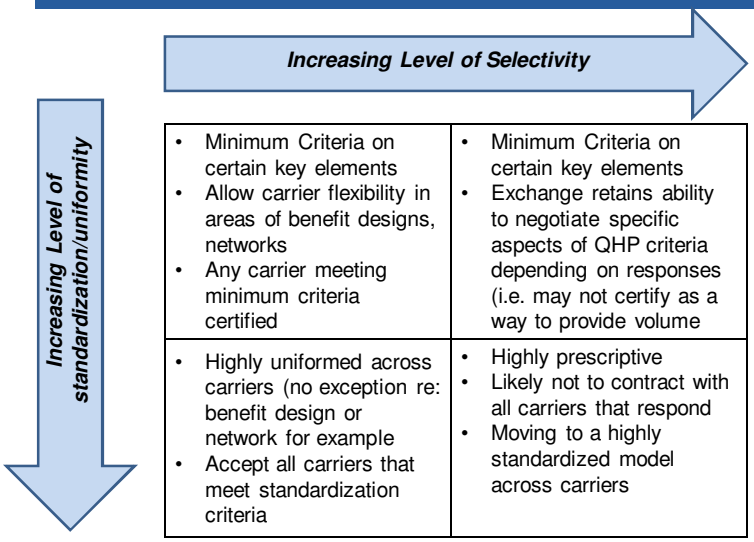
Certification Options (con't)



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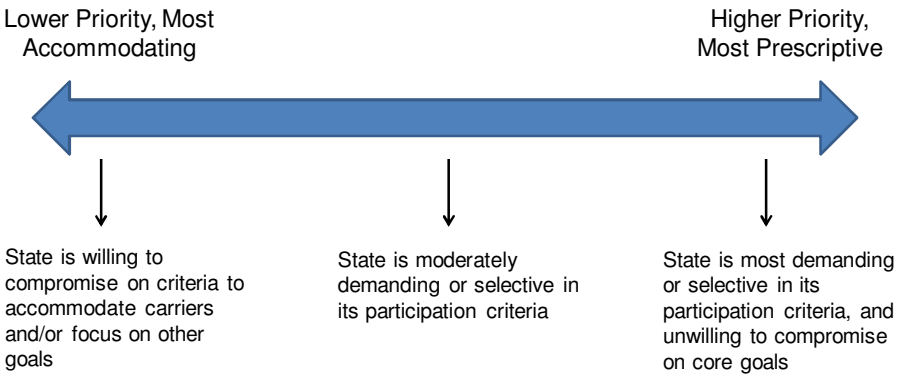
Calibrating Selectivity for Each Goal

The Exchange may adjust the level of selectivity and/or standardization it ascribes to any individual goal. This may be necessary to make trade-offs between goals based on the priorities it establishes for QHP certification.



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Selectivity Continuum – Examples

	Low	Moderate	High
Geographic Access	Require reporting on geographic access and network adequacy.	Require carriers to minimally offer in current regions. For those willing to expand, preferred placement in web comparison shopping page.	Require carriers to cover minimum geographic areas or share of state provider system as defined by the Exchange.
Delivery System Change	Require carriers to document and report on delivery-system reform initiatives	Provide favorable web site location for carriers participating in one or more designated care-delivery transformation initiatives (e.g., PCMH, ACO development, etc.)	Only allow participation from carriers with 20% of their network on global budgets or who participate in PCMH initiative

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Prioritizing Exchange Goals - Example

Exchange Goals	Level of Priority/Selectivity		
	Low	Moderate	High
Enrollment Growth			✓
Stability / Attracting Carriers initially			✓
Access			✓
Delivery System Change		✓	
Reducing Churn		✓	

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Certification Approach Example

Certification Approach #1: Exchange Starting Point

Goal	Selectivity	Certification Criteria/Terms
1. Enrollment Growth	High	Seek to offer at least 6 carriers, including the top five in the market representing at least 90% of NG/SM market
2. Stability / Attracting Carriers initially	High	Contract for an initial term of 2-3 years, with an option held by the exchange to add additional carriers after year 2
3. Access	High	Require carriers to minimally offer in the same regions as currently. For those carriers, willing to expand, preferred placement in web comparison shopping page
4. Delivery System Change	Moderate	Carriers receive web placement advantage by pursuing one of several reform initiatives recognized by Exchange
5. Reducing Churn	Moderate	Carriers must participate in state-sponsored customer support training to help manage member transitions

Certification Approach Example (Cont.)

Certification Approach #2:

Carriers strongly object to access provisions. This jeopardizes carrier participation goals. In response, Exchange relaxes requirements for access to preserve desired level of carrier participation.

Goal	Selectivity	Certification Criteria/Terms
1. Enrollment Growth	High	Seek to offer at least 6 carriers, including the top five in the market representing at least 90% of NG/SM market
2. Stability / Attracting Carriers initially	High	Contract for an initially term of 2-3 years, with an option held by the exchange to add add'l carriers after year 2
3. Access	Low	Carriers must provide reporting related to geographic access and network adequacy
4. Delivery System Change	Moderate	Carriers receive web placement advantage by pursuing one of several reform initiatives recognized by Exchange
5. Reducing Churn	Moderate	Carriers must participate in state-sponsored customer support training to help manage member transitions

Certification Approach Example (Cont.)

Certification Approach #3:

Carriers strongly object to all requirements. To better attract carriers, Exchange works with state to make participation in Public Employee and/or Medicaid MCO program contingent upon participating in Exchange and meeting criteria.

Goal	Procurement Criteria/Terms
1. Enrollment Growth	Seek to offer at least 6 carriers, including the top five in the market representing at least 90% of NG/SM market
2. Stability / Attracting Carriers initially	Contract for an initially term of 2-3 years, with an option held by the exchange to add add'l carriers after year 2
3. Access	Require carriers to minimally offer in the same regions as currently. For those carriers, willing to expand, preferred placement in web comparison shopping page
4. Delivery System Change	Carriers receive web placement advantage by pursuing one of several reform initiatives recognized by Exchange
5. Reducing Churn	Carriers must participate in state-sponsored customer support training to help manage member transitions
6. Medicaid/DBM Plan Contingency	Participation in Medicaid MCO and/or DBM employees program contingent upon participation in Exchange on meeting criteria

Agenda

- Goal of Today's Meeting
- Review Exchange Goals from Previous Meeting
- Discuss Certification Approaches
- Introduce Market Context
- Continue Discussion of Goals and Criteria

Impact of Market Structure on Criteria

The QHP certification process will unfold in a specific market context, and Exchange goals and criteria will be shaped by factors unique to Maryland.

Carrier Market

- Market concentration
- Product offerings
- Existing quality, delivery system initiatives
- Geographic coverage
- Sales channels

Provider Market

- Market concentration
- MD/System integration
- Quality performance
- Reimbursement levels
- Carrier/Contracting relationships

Consumer Experience

- Coverage and access
- Buying patterns
- Areas of discontent
- Coverage transitions
- Health needs

Regulation

- Existing coverage programs
- Insurance regulations
- Provider/Reimbursement regulations
- ACA implementation
- Rate review

Agenda

- Goal of Today's Meeting
- Review Exchange Goals from Previous Meeting
- Discuss Certification Approaches
- Introduce Market Context
- Continue Discussion of Goals and Criteria

Continue Discussion of Goals/Priorities

- Prioritizing Goals
- Specific vs. General Criteria
- Preserving Option for Selectivity
- Level of Selectivity
- Level of Standardization

Next Steps

Meeting Date	Discussion Topics
October 3, 2011	• Role and Opportunities of the Exchange • Concepts for Discussing Procurement Options • Identify and discuss procurement goals for the Exchange
October 12, 2011	• Discuss how preferred goals map to procurement strategies • Introduce and discuss procurement approach examples • Introduce how market context can shape strategy
October 25, 2011	• Discuss interaction between market environment and exchange goals in shaping options for procurement approach • Discuss refined procurement approach based on committee feedback from 10/12/11
November 2, 2011	• Discuss key elements of initial draft report and receive committee feedback
November 7, 2011	• Deliver Final Vendor Report

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Appendix 5

Maryland Health Benefit Exchange Operating Model and Insurance Rules Advisory Committee

Meeting #3

October 25, 2011

Agenda

- Summary of Market Information
- Discussion of Principles and Options
- Regional Contracting

Summary of Market Information – Key Takeaways

- Concentrated market -- critical consideration to ensure adequate scale for exchange
- Little overlap between Medicaid and Commercial insurance markets
- Unique state regulatory environment creates challenges and opportunities for exchange

Agenda

- Summary of Market Information
- Discussion of Principles and Options
- Regional Contracting Options

Today's Goal

- Review discussion of key concepts and key question posed to committee
- Discuss desired principles of QHP certification
- Discuss pros and cons of certification model options

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Appendix 5

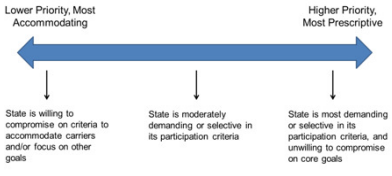
Key Concepts

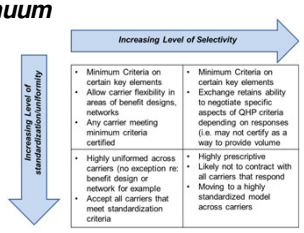
Starting Point: Either/Or

Exchange as Facilitator

Exchange as Selective Contractor

Key Concepts Identified by Wakely: Flexibility/Continuum





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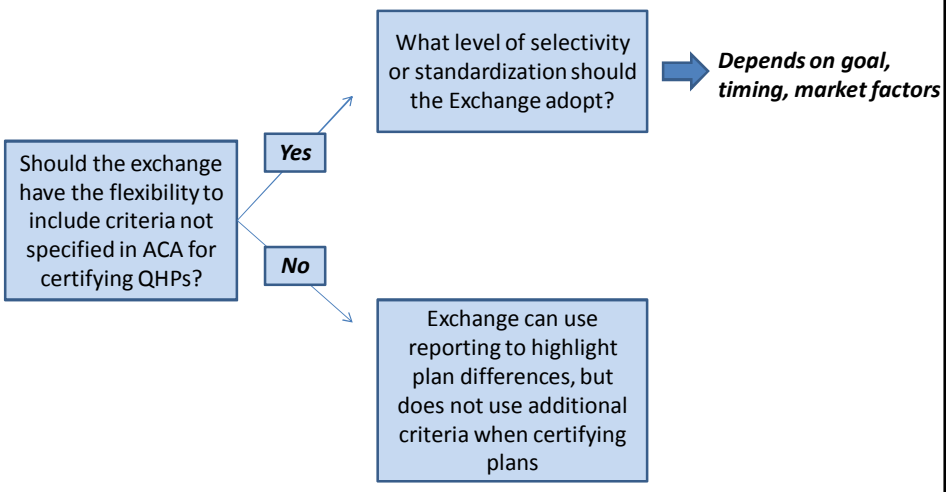
Appendix 5

Key Decision



QHP Certification Principles (Examples)

- The exchange should retain the flexibility to include QHP criteria above and beyond the minimum specified in the ACA
- The exchange should be cautious about including criteria that may limit the number of health plan choices
- In the short term, QHP certification should seek to build scale and stability for the exchange
- In the longer term, QHP certification should incorporate criteria to improve access to care, consumer experience, managing member transitions/reducing churn, delivery system improvement, and affordability

Options for Exchange Approach

- *Federal guidance highlights four examples of exchange certification options, outlined below and in following slides*
- *Other options or combinations of options are also possible*

1. Utilize an "any qualified plan" model (min. stds)
2. Develop selection criteria beyond minimum standards (an expanded version of #1.)
3. Competitive bidding or selective contracting model
   - E.g., Exchange issues a competitive RFP
4. Negotiate with carriers on a case-by-case basis, after carrier has met minimum cert standards

1. Any Qualified Plan

Pros

- Maximum choice in products and plans
- Provides greater chance to build scale by being more inclusive
- If supported with reporting on plan performance and support tools, gives consumers greater ability to find benefits that most fit their needs

Cons

- Too much choice can be confusing to members and diminish buying experience
- Limits exchange ability and flexibility in using certification process to advance other goals
- Minimum standards may not attract carriers necessary for successful exchange

2. Selection Criteria Beyond Minimum Standards

Pros

- Provides Exchange ability to advance some additional goals without limiting carrier participation
- Provides Exchange flexibility to include or not include standards that are more or less stringent based on particular context/market factors

Cons

- Calibration of standards important to ensure desired level of participation
- Exchange ability to maximize influence for certain factors may require ability to not include all carriers
- Could result in negative outcome for some carriers wishing to work with exchange

3. Competitive Bidding or Selective Contracting

Pros

- Provides greater ability to influence plan features, affordability, and advance quality/policy goals
- At large levels of enrollment, allows the exchange to have market-wide impact on key goals

Cons

- Does not require exchange to exclude carriers, but creates potential that some carriers will not participate
- At low levels of enrollment, exchange value proposition may not be sufficient to attract competitive proposals

4. 1:1 Negotiation with Qualified Plans

Pros

- Provides exchange greatest level of flexibility in establishing criteria and terms for participation
- Allows refinement of exchange/carrier relationship based on feedback and dialogue

Cons

- Does not require exchange to exclude carriers, but creates potential that some carriers will not participate
- Exchange ability to achieve goals depends on value proposition to carriers for participation

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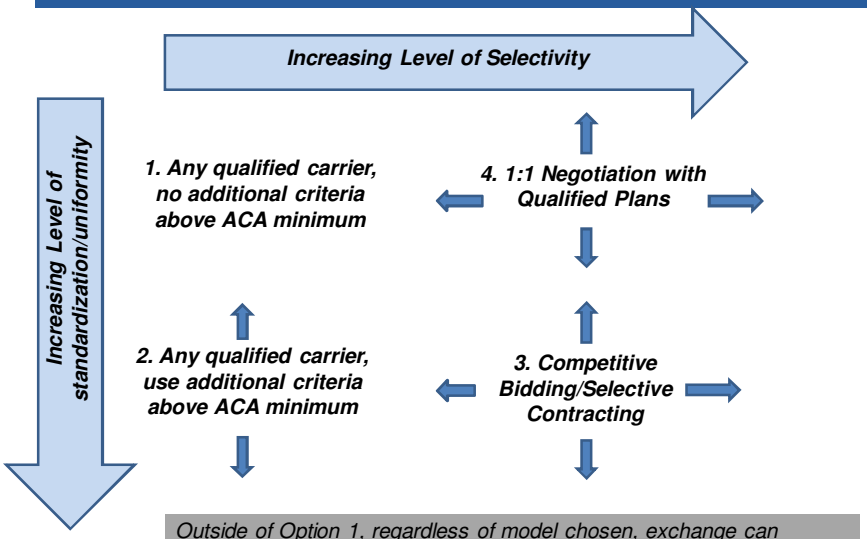
Certification Options (con't)



Outside of Option 1, regardless of model chosen, exchange can calibrate appropriate level of selectivity/standardization

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Appendix 5

Agenda

- Summary of Market Context
- Discussion of Principles and Options
- Regional Contracting

Options for Regional Contracting

Option 1: Baseline

- Allow Maryland-licensed carriers to participate, in addition to at least two national plans selected by OPM (who must also meet licensure and other criteria in Maryland)

Option 2: Facilitate Regional Coverage

- In addition to baseline, incorporate criteria to ensure participating plans can support cross-border business
  - Product features that enable multi-state coverage (e.g. for businesses with non-MD employees)
  - Require PPO options
  - Out-of-Network Options
  - Evaluate breadth of cross-state network

Options for Regional Contracting (Cont.)

Option 3: Collaborate with Other State Exchanges

- Joint or reciprocal certification process
- Shared data collection and/or review process
- Has implications for market participation, regulation and licensure
  - Per ACA, carriers must be licensed in both states to be offered through exchange
  - If carriers not currently in market and Maryland wishes to include on the exchange, will need to evaluate reasons for non-participation and/or otherwise incentivize market participation

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Maryland Health Benefit Exchange Operating Model and Insurance Rules Advisory Committee

Supplemental Information

October 21, 2011

Purpose of Document

- The information included in this document is intended:
  - To provide the committee with additional context relative to the health care market in Maryland
  - To respond to specific questions that have been raised by committee members during prior discussions

Minimum Certification Criteria

- *All qualified health plans and issuers must meet minimum criteria in statute and subsequent regulations (summarized below and in supplemental memo)*
- *States may include additional criteria they deem it in the "interest of qualified individuals and qualified employers in the state."*

Components of ACA Minimum QHP Criteria*

- Licensure Compliance
- Offering requirements
  - Silver/Gold/Child Only
- Rating rules compliance
- Network adequacy
- Transparency in coverage
- Quality standards
- Marketing Compliance
- Risk Adjustment compliance
- Accreditation
- Premium rate submission compliance
- Benefit design/Essential Benefits
- Service Area Coverage
- Enrollment processes
- Non-discrimination

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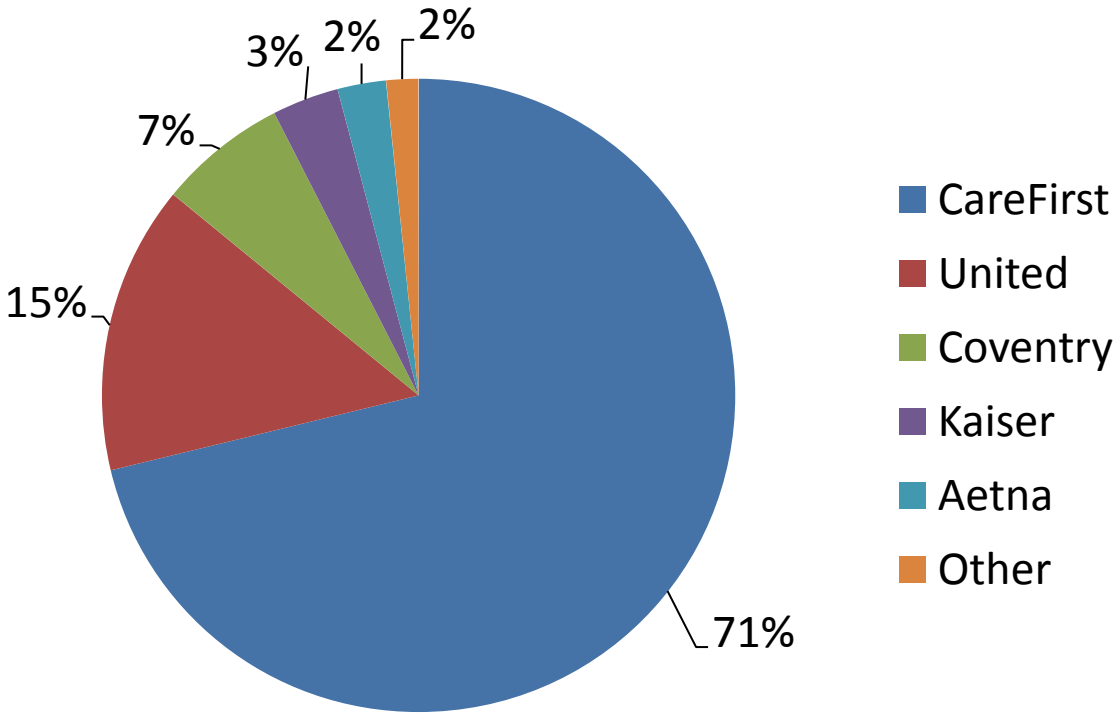
*Detailed summary of specific criteria included in separate document under same cover.

Market Concentration

- *Both the non and small group markets in Maryland are highly concentrated, with similar distribution by carriers.*
- *CareFirst accounts for 71% of the total small and non-group market. Overall, five carriers account for 98% of the market.*
- *This is important factor for the exchange to consider in relation to carrier participation and enrollment scale.*

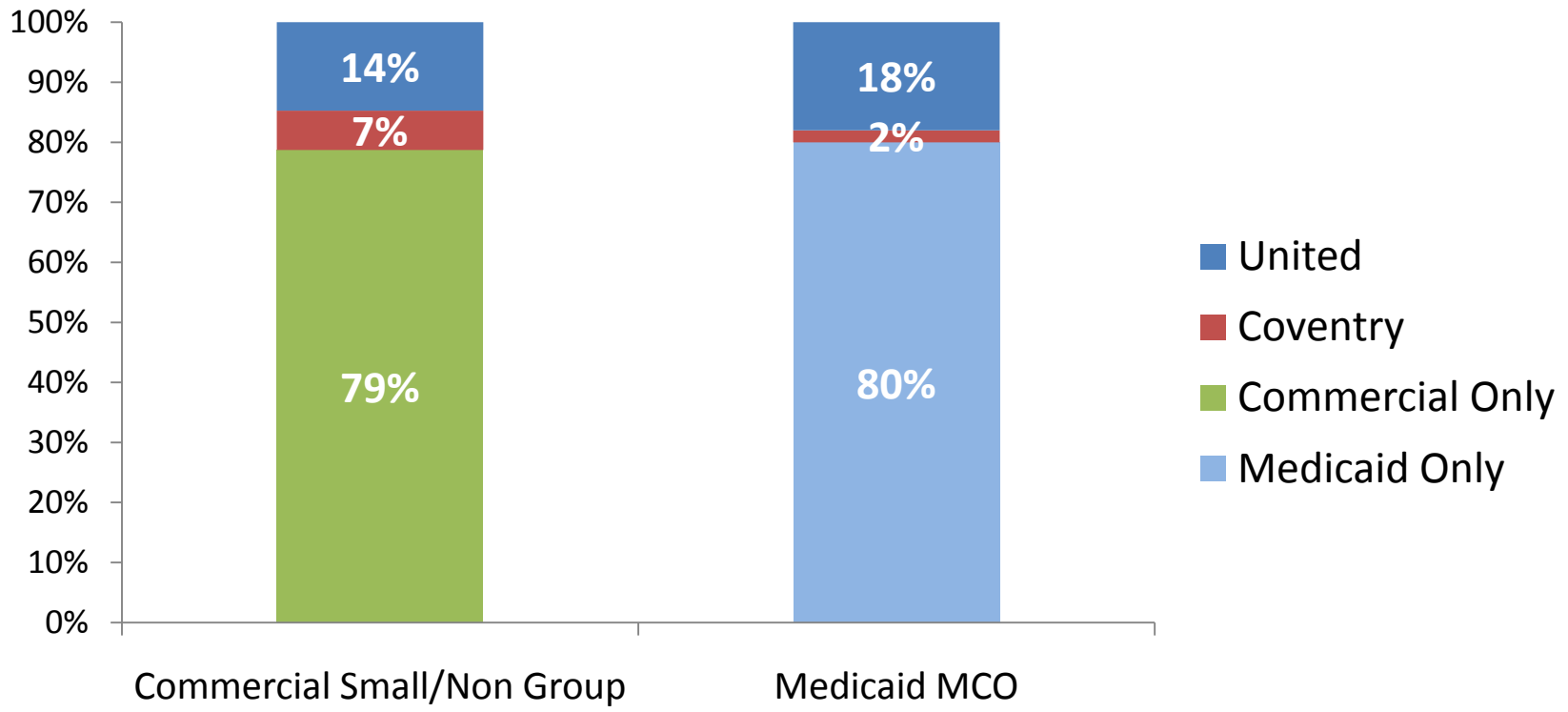


Hospital Rate Regulation

- Maryland's unique rate setting methodology places some limits on the ability of carriers to achieve greater savings through network contracting
  - Hospital rates for all payers are regulated by the HSCRC, which provides Maryland greater long term cost control abilities but limits carrier opportunities to further impact affordability through preferred rates
- Network composition (i.e. limiting networks), product design, delivery system changes (PCMH, global budgets) and utilization management may be other options to enhance affordability

Medicaid/Commercial Market Overlap

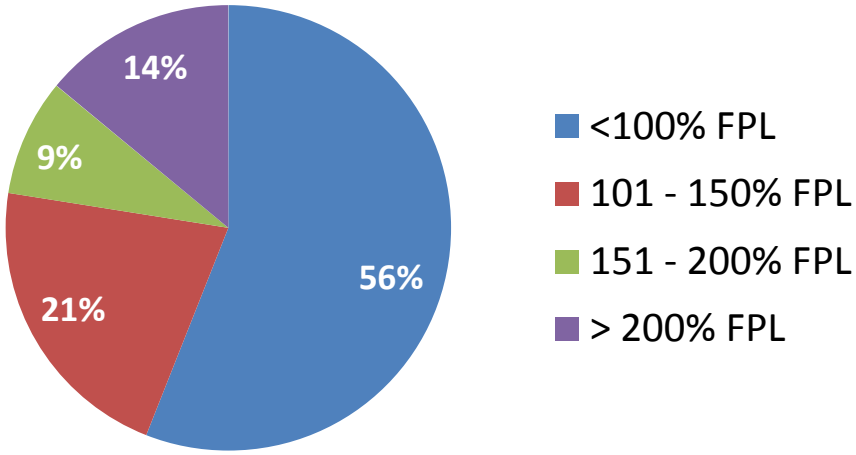
Only two carriers participate in both the commercial small and non-group markets and the Medicaid MCO market, accounting for approximately 20% of both markets.



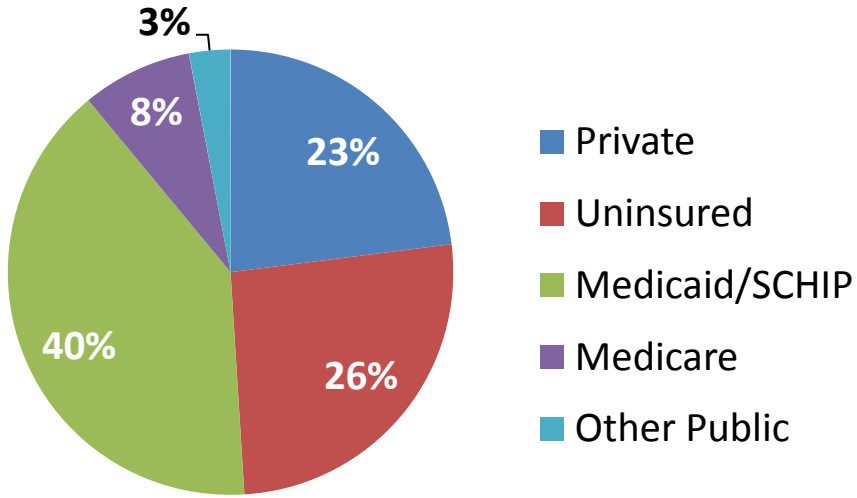
Medicaid/Commercial Market Overlap (Cont.)

- *A little less than a quarter of CHC users have private insurance.*
- *Most CHC users fall at income levels below the Exchange target market, although between 25 and 45% may fall into the Exchange market if no BHP is enacted.*

Income Status of CHC Patients, 2009



Insurance Status of CHC Patients, 2009



Source: Mid-Atlantic Association of Community Health Centers, 2009

Appendices

- We have included two separate memoranda to supplement information included here:
  - Detailed summary of ACA minimum QHP certification criteria
  - Description of two successful private exchanges, and side-by-side comparison of Massachusetts and Utah exchange experience

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